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LEADING ARTICLES

THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.*

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SAN ANTONIO, TEY.

The central idea of all legislation, whether National, State or Municipal, relative to infectious and contagious diseases, is that they they are largely preventable, if not entirely so. The possibility of prevention conceded, it stands to reason that the earlier disaeses of this nature are detected, the greater will be the opportunity to protect others from infection. From the standpoint of preventative medicine, therefore, the early diagnosis of any infectious disease is of the first importance. Again, if we view the bacterial diseases from the standpoint of treatment, we find this undeniable principle: that the sooner patients are brought under control and proper treatment instituted, the lower the mortality. This is especially true when specific remedies of any kind are to be administered. Thus, from the standpoint of applied therapeutics, the early diagnosis is again of prime importance.

The significance of a disease is directly in proportion to the duration of the period of disability it causes, the average age of its victims, and the mortality. For these reasons, tuberculosis, with an average period of disability exceeding two years, an average age at the time of death that falls in the very middle of the most productive period of life, and a fatality nearly equal to that of typhoid fever, measles, scarlet fever, pertussis, diphtheria and pneumonia combined, easily stands at the head of all infectious diseases in importance. Again, it is conceded that tuberculosis is both preventable and curable when discovered in time. Its early detection, is therefore, demanded. View it from whatever standpoint you will, sanitary, medical, racial or commercial, its early determination becomes imperative.

Yet, notwithstanding the necessity which must be evident to every thinking physician, it is a matter of common observation that tuberculosis has not been recognized in the past, and is largely unrecognized today, until it has advanced beyond that point where human aid is available. It is probable that in a certain per cent of cases, it is never recognized at all, and deaths in such instances attributed to intercurrent diseases. It is safe to say that nearly fifty per cent of the cases of tuberculosis are not recognized as such until in the second and even third stage, thus neither affording the patient an opportunity for recovery nor for safe-guarding his family, his fellow-workers and the public. Experience teaches us that fully 75 per cent of those who come to this part of the Southwest for the so-called "climatic cure" are in the third stage of tuberculosis, and in a physical condition—and I might say in a financial condition—that common humanity should dictate that they remain in their homes with what comforts they may be able to surround themselves—much less "get out and rough it," as they are so frequently directed to do.

The failure to recognize the incidence of tuberculosis in season is undoubtedly due to several causes. The patients themselves are often responsible for not seeking competent medical advice in time. The term "consumption" has been, for ages, associated in the lay mind with emaciation, weakness, cough, expectoration, fever, nightsweats, etc., and the public largely does not yet realize that this condition is only the manifestation of the near approach of the termination of the tuberculous pro-

*Read before the Medical Association of the Southwest at San Antonio, Tex., November 11, 1909.

cess in death. The months and months of malaise with slight fever is chronic malaria. The disorders of digestion are liver trouble or biliousness. Tuberculosis to them only means "consumption." They do not understand that many cases may manifest few or none of these symptoms, and yet be beyond all hope of recovery. Indeed, it is only in the last few years that we, ourselves, have come to understand that tuberculosis may be well advanced before the train of symptoms commonly spoken of as consumption appear. Even in those instances where the disease might reasonably be expected, the laity often fails to seek the advice of the physician in time. All the mental processes of the lay mind are away from recognition—a slight indisposition, "a slow fever which baffles all the doctors."

We cannot hold the medical colleges altogether blameless for this condition. They have been and are today entirely too numerous. They must come in close competition with each other for students, with the inevitable result that the entrance requirements are lowered, not raised. Success in a commercial sense, rather than scientific, is demanded. With insufficient endowment and equipment, the school attempts the impossible—that is, to make the finished physician out of entirely too raw material. The young doctor graduated from such institutions is turned adrift upon society to succeed or fail, as the case may be. With this failure of the medical schools to sufficiently train their graduates in physical diagnosis and bacteriology, and omitting altogether the tabooed subject of tuberculosis, it is little wonder that the disease is so frequently undetected in its incipiency.

Again, the physician has his responsibility. When a disease takes 10 per cent of his patients and is an underlying cause of the illness of probably 50 per cent more, he should fit himself to recognize it at the earliest possible moment. But the general practitioner to whom these patients usually first apply, is often unable to devote the necessary time to the individual patient to detect the disease in its incipiency, much less instruct his families in its prevention. The inhibition of supposed helplessness in the presence of tuberculosis has produced its legitimate results. The average physician has not put forth his best energies in mastering the disease. The present spirit of optimism that now pervades a large per cent of the profession may not be fully warranted, but it will be productive of good results in stimulating scientific investigation.

It is commonly agreed that tuberculosis should be discovered in its incipiency, and that an early diagnosis should mean the detection of the disease during this period. But just what signs we may expect to find during this period, and when the disease has advanced into a later stage, diagnosticians are not so well agreed. Ordinarily, in speaking of an early diagnosis, we mean the recognition of the disease before those symptoms appear which indicate the destruction of pulmonary tissue. I would emphasize this point, that when evidence of such changes are manifest, the case is no longer in the incipient stage.

The following case represents to my mind a typical instance of incipient tuberculosis:

Mr. A., age 35; weight normal, apparently in fair physical condition, indoor occupation, and bad family history. Had contracted syphilis during youth. Attention directed to pulmonary condition by continued subnormal tepmerature during morning hours, slight but persistent cough with light expectoration, and digestive disturbances. A study of this case showed a variation of the pulse from 76 to over 100 per minute, and the temperature ranged from 97½ deg. F. a.m. to 100½ deg. F. p. m. Physical examination of the chest revealed as follows: Right lung—upper lobe—roughened inspiration over first and second interspaces, below inner third of clavicle; lower lobe—posteriorly below scapula harsh and slightly interrupted inspiration on auscultation, and slight dullness on percussion. Left lung—upper lobe anteriorly—harsh, interrupted inspiration, prolonged expiration and moist rales on auscultation, and small area of dullness on percussion. Examination of sputum negative. Tuberculin tests—hypodermic and cutaneous, gave positive reactions.

An analysis of the examination indicates three foci of infection, two small foci in the right lung—one in the upper lobe anteriorly, and the other in the lower lobe posteriorly—with slight infiltration; and a third focus in upper lobe of the left lung, anteriorly, of larger area and greater infiltration. The result of the tuberculin test is simply confirmatory of the physical findings. There were no destructive changes.

Some writers give hemorrhage as among the early signs, and others lay stress upon the appearance of the tubercle bacillus in the sputum. But, as both of these indicate the presence of destructive changes, a diagnosis resting on one or both of them should

hardly be called early. It is true that a small tubercle may caseate and break through the membrane, giving rise to a small hemorrhage and the appearance of tubercle bacilli, but this does not usually occur before large areas of infiltration are present, and other marked symptoms indicating a later stage. As a matter of fact, a diagnosis based upon these two positive signs is too late to be of much value to the patient in aiding him to make a permanent recovery. In truth, with our present knowl edge of tuberculosis— its symptoms and pathology, and with the diagnostic aids at our command, we should make a positive diagnosis long before the appearance of those signs which usher in the so-called second stage. As the incipient stage of tuberculosis may extend over a period of months, and even years, we should make a sharp distinction between an early stage of the disease and an early diagnosis. A diagnosis during the latter part of the first stage is only comparatively early.

The following sentence occurs under the head of diagnosis of tuberculosis in a text-book on practice, that probably now finds its way into the hands of nearly every medical student: "The irregular fever, cough, pallor, emaciation, hemoptysis, nights sweats, signs of consolidation and the presence of the tubercle bacilli in the sputa, are diagnostic phenomena." These are, undoubtedly, "diagnostic phenomena," but they are the signs of the second and even third stage of tuberculosis, and when they occur, it should hardly require the trained senses of a physician to make a diagnosis of the disease. It is self-evident to the laity. Another text-book states: "The general and local symptoms, including the physical signs, may afford merely a strong suspicion of the existence of phthisis, and in such instances, repeated examinations of the sputum for the bacilli are imperative, and only when they are found, is the diagnosis set at rest." It is now generally conceded that the appearance of the tubercle bacllus strongly indicates the near approach, or the actual presence, of the second stage. If we depend upon finding the tubercle bacillus in the sputum before making a positive diagnosis of tuberculosis, we may never make an early diagnosis.

In making a diagnosis of pulmonary tuberculosis, our greatest reliance must still be placed in the physical examination of the chest. We resort to other means as a rule merely to confirm our physical findings. There is nothing, so far, that can take the place of a careful examination of the chest. The accuracy of results attained will be in direct proportion to the methodical manner in which it is made, and the knowledge displayed in the interpretation placed upon the signs discovered by the senses of touch, sight and hearing. A good eye, a trained ear, and an educated sense of touch are indispensable, but they are no more indispensable than an accurate knowledge of a normal chest and a normal lung. The first thing in placing an interpretation upon an abnormal condition is to determine the degree of its variation from the normal.

In making a thorough physical examination, there are a few instruments that are essential. There are some authors who disclaim the use of such instruments, preferring to rely upon the direct evidence perceptible to the unaided senses. Nevertheless, the use of the tape-line, the plessimeter and hammer, the stethoscope and the phonendoscope make for accuracy and precision. The failure to be accurate and precise in our diagnostic methods is frequently the prime cause of our failure to achieve more perfect results in general medicine.

The preparation of the patient for an examination is not unimportant. The clothing should be removed down to the waist, and a light kimona—open front and back —thrown over the patient's shoulders. To attempt to make an examination of the chest through one or more thicknesses of clothing where the utmost discrimination is needed, is worse than folly. It means failure as an examination, uncertainty as to results, and indicates either carelessness, timidity or ignorance on the part of the examiner. The position of the patient is worth nothing. He should be seated—preferably on a stool, although a straight backed chair may be used. He should sit upright, so as to bring the organs into a normal position, and directly in front of the examiner, with the arms in an easy, natural position, so as not to interfere with the natural movements of respiration. An awkward position is uncomfortable to the patient. It prevents the examiner from making correct observation of the chest movements, and may result in erroneous conclusions. The purpose of the examination is to draw definite conclusions from accurate observations, and the technique should be as perfect as possible.

In the methodical examination, mensuration, inspection, palpation, percussion and auscultation each has its place. Mensuration gives us more or less definite information as to the capacity of the lungs—the actual expansion of the chest walls, and

the relative expansion of the two sides. In other words, we are enabled to a certain degree to determine whether, through infiltration or adhesions, either or both lungs have lost to an appreciable degree their normal elasticity. Of course, if we limit our definition of incipiency to slight initial lesions, such as the infiltration of one apex, or a small area of one lobe, mensuration will give us very little information, as these early changes are not usually associated with any marked deviations from the normal.

Inspection, likewise, in these cases may not discover any marked changes in the external appearance. Indeed, the patient may appear to be in almost perfect health. It may, however, reveal a relative emaciation; that is, comparatively thin chest walls, the undeveloped muscular system characteristic of the strumous, and the habitually under weight. Deficient movement of the chest wall there may or may not be. Depressions are not apt to be found as in the later stages. The capillaries of the skin may appear dilated over the area of infection, and especially over the attachments of the diaphragm.

Palpation, however, may furnish us with some very definite information. Localized areas of tenderness or pressure are quite frequent in incipient pulmonary tuberculosis. They may be elicited on percussion. The most frequent points of tenderness may be located anteriorly just above and below the middle portion of the clavicle, and posteriorly just above and internal to the inner angle of the scapula. Other points may be elicited according to the location of the foci of infection, and the extent of the inflammatory processes. These sensitive areas indicate superficial inflammatory changes in the lungs, involving the pleura, more or less, and are probably due to rubbing and traction upon the pleura. I have found these areas tender to the touch in many cases. They are probably present in over 50 per cent of all cases. The occurrence of these sensitive points is considered by some as a very early diagnostic sign of pulmonary tuberculosis.

Percussion in the early incipient stage is of little value, but, as infiltration advances, it may elicit increasing areas of dullness. As pulmonary tuberculosis almost invariably begins in the apices, we must look in these regions for the first signs of the impairment of the normal resonances. The precussion points where an impaired note may be reasonably expected, correspond closely with the localized points of tenderness anteriorly and posteriorly, and indicate inflammatory changes producing greater density of the pulmonary tissue; that is, infiltration. As soon as the tuberculous process is set up, infiltration begins, and progresses by contiguity of tissues, with constantly increasing areas of impairment of function.

Auscultation, however, is our chief reliance in the early incipient stage, as it gives us the most important information. There are several sounds heard on auscultation that very early indicate tubercular changes in the lungs. But we must remember that the tuberculous process is slow, and that these signs usually appear months after the primary infection. To appreciate these early signs, the examiner must have a clear conception of the normal sounds, and the diagnostician should lose no opportunity to examine the lungs of healthy individuals. We should always regard any deviation of the breath sound over the apices from the normal as indicative of tuberculosis. In normal repsiration, the inspiratory murmur is smooth and regular, and is more intense and of longer duration than the epxiratory murmur, which may not be heard at all. An interrupted inspiratory murmur, and a prolonged, accentuated expiratory murmur should always excite suspicion. These sounds are not natural, and have a definite pathological significance. Interrupted inspiration is due to infiltration and tubercle formation which interferes with the normal elasticity of the pulmonary tissue. The prolonged expiration is due to the same cause, and when it equals or exceeds the inspiratory sound, and becomes rough or harsh in character, we may assume an inflammatory condition underlying the ear or instrument to exist. These two sounds, when heard over the upper lobes, almost invariably indicate tubercular changes. Rough or harsh inspiratory sounds appear during the acute inflammations of the mucous membrane of the respiratory tract, but when they persist in the absence of acute infections, especially in the apical regions they possess an undoubted significance. As infiltration increases, there is a further deviation from the normal — the air cells become closed and finally obliterated, and the breath sounds take on the bronchial character. The bronchial murmur means more or less extensive consolidation.

If the inflammatory processes extend to the pleura, as they frequently do, the dry, inflamed pleura yields the friction note. When we remember that pleurisy is nearly always of tubercular origin, and is often

the earliest manifestation thereof, we have a sign of unusual significance.

As tuberculosis is a most serious malady, and its early detection imperative, both from the standpoint of treatment and sanitation, when the physical examination does not yield conclusive evidence either of the presence or the absence of the disease, it is not only our right, but our duty to insist upon other diagnostic aids. The patient should not be dismissed with the statement that he is threatened with the disease. He either has it, or he does not have it. Fortunately, we have the tuberculin test and the X-ray.

There seems to be among the profession an unwarranted prejudice against the use of tuberculin in determining the presence of tubercular infection. It is, nevertheless, an early and very positive test. In bovine tuberculosis, it is proven to be accurate in 97 per cent of the cases tested. It is no less certain in human tuberculosis. We have no other means that is even approximately positive. It should not, however, be used indiscriminately. Its use should be limited to those cases where confirmatory evidence is desired. It should not take the place of the physical examination. We now have the choice of different methods of employing it, the subcutaneous, the conjunctival, and the cutăneous. Personally, I prefer the subcutaneous injection of tuberculin, as affording the most positive results. If, for any reason, this cannot be done, or the physician wishes to avoid the systemic effects, the other methods may be employed. There is some objection to the conjunctival test on account of the delicacy of the eye and the supposed danger of setting up an uncontrollable inflammation therein. The cutaneous test had met with almost universal favor because of the absence of all danger. Because of the simplicity of technique it is particularly available in children

The X-ray gives us much valuable assistance in the early detection of tuberculosis. It may reveal the existence of areas of increased density in the lung tissue, the presence of calcareous deposits, the location of enlarged bronchial glands, and the limited movements of the diaphragm, before the usual physical signs develop. If we accept the existence of a lymphoid stage in tuberculosis; that is, the glandular system acting as the primary seat of infection, and the disease spreading therefrom by contiguity of tissue and the blood current, the importance of the X-ray as an instrument of precision is apparent to every one conversant with the subject. As infiltrtaion extends the density of the infected area is likewise increased, and is apparent when compared with the opposite healthy lung. Whenever infiltration has extended to any considerable degree, or over any considerable area, the expansion and contraction of the pulmonary tissue is restricted to a greater or less extent. This difference in the elasticity between the diseased lung and the normal one—manifest clearly in the excursions of the diaphragm—is quite apparent to the trained eye.

Aside from what we have already discussed—the physical examination, the tuberculin test and the X-ray—there is a symptom-complex which we must take into consideration. The patient does not usually consult the physician without some tangible reason for his action. There is usually some pronounced symptom or train of symptoms which causes him to do so. Of 216 cases studied by Coffman, 114 gave a persistent cough as the first symptom; 64 gave loss of weight and easily induced fatigue; 20 hemoptysis, and 18 pleurisy. In my experience, the symptom-complex most frequently observed is slight, unproductive cough, associated with slight rise in temperature, considerable increase in the rapidity of the hart's action, more or less disturbance of the digestive function, and irritation of the nervous system. The cough may be, and usually is, dry and hacking. It persists unduly after colds and influenza—in fact, in the patient's mind, is unreasonably presistent. This happening in a person who has been freely exposed to the danger of infection, should at once excite suspicion. The variations in temperature are of great importance, and should never be overlooked. A persistent evening rise of one-half degree to one and one-half degrees, associated with a corresponding morning depression, is diagnostic of phthisis. There is no other symptom so uniformly present in incipient tuberculosis. It should not be forgotten that when variations in temperature occur, there is a definite cause. With almost equal constancy we find an acceleration of the pulse rate, especially on slight exertion. This is due to the effect of the toxins upon the nerve centers, regulating the heart's action, and seemingly their especial affinity for the involuntary muscle fibers. Disorders of the digestive system are quite constant and not infrequently it is for this symptom that the patient seeks relief. Here again, the bacterial poisons are producing their toxic effects, destroying the tone of the gastric muscles, deranging the nervous mechanism and diminishing the glandular secretions. Nervous disturb-

ances are not infrequent. Sometimes this disturbance is manifest in an increased irritability; at other times it takes the form of a mild depression. As all bacterial toxins seem to possess a special affinity for the more highly differentiated tissues, particularly the higher nerve cells, it is not strange that we frequently find a marked neurasthenia. It is almost a universal experience that neurasthenics, sooner or later, develop an active tuberculosis. It has been my experience that they uniformly react strongly to the ordinary tubercuiln tests. It seems to me that tubercular infection is too frequently overlooked as the underlying cause of neurasthenia. A condition of persistent nervous irritation or depression should excites suspicion and invite investigation.

I wish to direct your attention to the frequency of pleurisy as a primary symptom of tuberculosis. Leaving out of the question the old contention of many writers that pleurisy is practically always of tubercular orign, it is of sufficient frequency to be pathognomonic of infection. Coffman found it present as the initial symptom in about nine per cent of the cases studied. In my own cases a very large per cent give a history of one or more slight attacks of pleurisy. It is a sign that should never be overlooked, and its presence should always lead to a careful determination of its actual cause. It is highly probable that a very large per cent would yield a positive tuberculin reaction. We should always regard pleurisy as indicating the possibility, if not indeed the high probability, of tubercular infection.

Hemoptysis is another symptom pathognomonic of tuberculosis. While Coffman found it in nearly 10 per cent of his cases to be the first sign that attracted the patient's attention to his lung condition, it is not truly an early sign. Because it makes a very vivid impression upon the patient's mind, and is the first tangible evidence he has, he is apt to speak of it as his first symptom; but, like the appearance of the tubercle bacillus in the sputum, with which it is usually associated, it indicates the breaking down of pulmonary tissue and the erosion of some small blood vessels, which pathological condition does not belong to the incipiency. We should, therefore, regard it as the announcement that softening and cavity formation has begun, although the area involved may be small in a majority of cases. We will, however, meet with cases in which other pronounced clincal symptoms are wanting, and in such, its true significance is very often underestimated. These cases, almost without exception, develop the disease. We not infrequently hear of persons having had several hemorrhages years ago, and no later inconvenience.. This is merely an indication of a fortunate termination, rather than disproving the presence of the disease. Hemoptysis should always be reagrded as of tubercular origin until disproven.

The blood pressure, as indicating the vascular tone, is worthy of note. It is lower than normal in over 70 per cent of all cases, and it is rarely above normal in uncomplicated cases. In tuberculosis it falls as soon as toxemia exists. This is due to the dilatation of the capillaries and the weakening of the cardiac muscles.

Anemia is also an apparent sign of tubercular infecction. It is sometimes more apparent than real in the incipiency. The hemoglobinometer may inidcate a relatively high percentage of hemoglobin. Taken in connection with other signs, it indicates toxemia and lowered vital resistance.

There is one more condition which is frequently met and seemingly almost as frequently misunderstood. When the disease is progressing, there often develops a persistent fever, accompanied at tiimes with chills. The favorite diagnosis in these cases seems to be malaria. This is an error of entirely too common occurrence. A study of the patient and an examination of the blood for the malarial plasmodium would soon set all doubt at rest. I have not been able to find the malarial parasite in a single case of this kind. Considering the frequency of tuberculosis in some sections, and the comparative freedom from malaria, it is sometimes a matter of surprise that such a diagnosis should be made when the easiest possible diagnosis would have been the ocrrect one. Usually bodies move either in a straight line or along the line of last resistance, but in making a diagnoiss of tuberculosis, we seem to prefer the most circuitous and the most difficult line of mental action.

As I said in the beginning of this paper, the early recognition of tuberculosis is of the greatest importance, no matter from what standpoint we may look at it. If we are ever to control the disease, we must learn to detect it at the earliest possible moment. The public must know the importance of seeking competent advice in season, for the early recognition of tuberculosis not only affords its victim a fighting chance for his life, but insures greater protection to his family, his co-workers and the public.

STRICTURE OF THE MALE URETHRA.*

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Stricture of the urethra is an abnormal narrowing of some part of that channel which interferes with the free outflow of urine, due to either muscular spasm or to organic changes in the walls of the urethra.

Occasionally in the very young we meet a case where there is frequent micutrition both day and night, with some dribbling of urine, which symptoms are attributed to habit or meanness, by the parents. Even a physician, when consulted may make light of it and in so doing does the little patient a gross injustice, at least, until he has satisfied himself that there is no stricture. The constriction in the very young is located most frequently at the external meatus, but may be in the posterior urethra, and must be dilated, after which the disagreeable symptoms disappear. A certain amount of narrowing of the external meatus is normal and favors the projection of a strong stream of urine. Therefore, the division of a narrow meatus must be done very carefully, or the patient will be left with no projectile force.

Acquired strictures are either spasmodic, congestive, or organic.

The spasmodic is either reflex or psychical, and is usually due to an irritable compressor urethrae muscle. Among the causes are acid urine, hemorrhoids, pinworms, etc. Particularly apt to occur in young men who are the counterpart of hysterical women. A case came under my observation where the symptoms of deep stricture had existed for many years, which was relieved immediately and permanently by a single catheterization.

The congestive stricture is due to inflammatory swelling of the urethral mucous membrane, and frequently occurs during the acute stage of gonorrhea. If the retention is complete it is usually associated with a spasm of the compressor urethrae muscle. These conditions which are classified as spasmodic and congestive strictures are more properly speaking temporary obstructions, and not true strictures.

The most important and most frequent form is organic stricture, where there are actual changes in the wall of the urethra, forming a narrowing and rigidity. Sir Chas. Bell has described it as a condition in which the affected portion of the urethra has lost its dilatability.

Organic stricture may follow a severe traumatism causing a rupture of the urethral wall, and the resulting scar narrows the channel. I have seen some cases that resulted from the breaking of a chordee. It may be, and is in about 90 per cent of the cases, subsequent to gonorrheal urethritis. It follows repeated attacks of urethritis, or is preceded by a long continued attack of gleet. It seldom occurs before two years have elapsed since the original attack of gonorrhea, and may not give the patient much inconvenience for ten or twelve years.

The popular idea that a rapid cure of gonorrhea causes stricture is not based on facts, but on the contrary, the longer the duration of the attack the more liable is the patient to have a stricture. It is the exception for an urethra to become normal after even one prolonged attack of chronic inflammation.

The pathological process of stricture formation is a long story of cell infiltration and connective tissue formation (proliferation) which our limited time forbids us to discuss.

The site of the stricture is most frequent in the region of the bublo-membranous urethra, but may be near the external meatus. The great vascularity, together with the numerous glands and follicles found in this region necessarily form a rich field for the localization of chronic urethritis, thus predisposing to stricture. Gonorrheal strictures are never found in the prostatic urethra.

The urethra behind a stricture becomes dilated, a pouch is formed which is a most excellent container and incubator for the germs of sepsis. Thinning of the wall, and ulceration may lead to rupture of the urethra, with extravasation of urine, or to a periurethral abscess which may rupture externally, forming an urethral fistula. This fact argues for an early treatment of the stricture. In long standing, neglected cases the bladder takes on a compensatory hypertrophy as a result of repeated forcible efforts to empty itself through a narrowed outlet. In time cystitis may develop, to be followed later by involvement of the ureters and an infection of one or both kidneys.

In their incipiency strictures produce but slight disturbance. The intelligent man observes that it takes him longer to urinate than formerly. As the stricture increases and the lumen of the urethra diminishes, the bladder is never entirely emptied, hence micturition is more frequent than normally. Micturition is not very painful, except in

*Read before the Mississippi Valley Medical Association at St. Louis, October 14, 1909.

the extreme cases where the patient strains violently to force the urine through the narrowed channel. The forked, twisted stream is not characteristic of stricture.

Dribbling after urination is due to a few drops held behind the stricture, escaping after the bladder has emptied itself. This occurs as an early symptom. Dribbling from an over-distended bladder due to a stricture is a very late symptom and is worse during the day while the patient is up and about. When due to an enlarged prostate it is worse at night. Sudden complete retention may develop, and the patient is not able to pass even drops of urine. This is due to a sudden engorgement of the mucous membrane over the stricture, and may follow exposure to cold, the excessive use of alcohol, or sexual excesses, gleety discharge.

In order to save the patient a great deal of trouble and to avoid serious complications it is necessary to recognize the earlier stages of the stricture. When there is gleet, frequent micturition, dribbling after urination, with more or less hypogastric pain, we are justified in examining further.

In examining for stricture we must bear in mind that a spasm of the urethra is not a stricture in the proper sense of the term. If the surgeon accepts the patient's diagnosis, and begins at once to use a small sound, he may be misled into thinking a stricture is present when the obstruction to the introduction of the sound is caused by the point of the small sized instrument catching in a fold of mucous membrane. Again the small instrument will not detect a stricture that is not very narrow. Any instrument that will pass through the external meatus should without difficulty pass the rest of a normal urethra. Therefore, in order to ascertain the presence of a stricture, the first instrument to be used should be as large as the meatus will admit readily. The possibility of doing damage to the urethra, and of creating a false passage is far less with a large sound than with a small one. It is never wise to use much force in passing a sound. If the first in strument tried does not readily pass, try a smaller one, and so on until one is found that will pass. The wisest plan for all who are not specially skilled in the use of sounds and bougies is to refrain from the use of small metal instruments. The small flexible bougies, even in the hand of the unskilled will at least do no harm and will often be of great service.

The treatment of organic stricture is both general and local. In general, special attention should be given to the patient's hygiene. The diet should be bland and not stimulating. Alcohol and tobacco are to be excluded. Sexual excesses to be avoided. No exposure to cold and wet. Rest in the recumbent posture as much as possible. Alkalies internally to neutralize the urine is also beneficial.

The local treatment consists of using such measures as will overcome the abnormal narrowing of the canal, and restore as early as possible the normal dilatability of the urethra. The best way to accomplish this is by gradual or intermittent dilation. This applies to about 98 per cent of all cases when properly executed. The bougie or sound is the best instrument to use. The passage of a sound through a stricture not only acts in a mechanical way by increasing the caliber of the urethra, but it stimulates absorption of the inflammatory product. This requires patience on the part of both the surgeon and the patient. It must be done slowly. If too much is done at one treatment, the mucous membrane is damaged, which may produce more swelling and inflammation, thus defeating the very purpose of the treatment. In the beginning, sounds should be passed every three or four days. When a sound as large as 18 F. will pass easily, then once a week is often enough. Later once a month then two or three times a year.

All instruments must be scrupulously cleaned and sterilized. They should be warm and well lubricated before using. If possible it is well to keep the patient in bed from twelve to twenty-four hours before treatment. If the patient is very nervous it is quite helpful to give him twenty grains of sodium bromide and five grains of chloral about one and one-half hours before the use of the sounds or bougies. It also facilitates matters to give him a sitz-bath for twenty minutes just prior to treatment especially if there is much rigidity of the perineum. The penis must be held vertical and kept well on the stretch so as to obliterate the mucous folds of the urethra as much as possible.

Probably the most common error in the use of metal sounds is to think that the tip of the instrument is engaged in the opening of the triangular ligament before it really is, and the handle is lowered too soon, thus forcing the instrument through the roof of the urethra, thereby making a false passage. When the stricture has been reached, the surgeon should grasp the end lightly between the thumb and forefinger, manipulating it very much as he would a probe, employing the greatest of gentleness. Sometimes the forefinger of the other hand

can be used to guide the tip of the sound by making pressure on the perineum, or by introducing it into the rectum.

It is the very tight strictures that test the skill and patience of the surgeon. However, no stricture should ever be condemned as impermeable so long as the urine escapes even though it be by drops. If the smaller sounds do not pass then try the so-called filiform. If the first filiform does not pass leave it in place and introduce another and so on until one finds its way through. As many as twelve or fourteen may be necessary. In the absence of the filiform ordinary silk-worm gut liagtures will answer very well. Before attempting to pass the filiform, there should be instilled deep into the urethra, with an urethral syringe, ten drops of a 2 per cent cocaine solution to which has been added five drops of solution adrenalin (1-1000). This will lessen the irritability of the urethra, and diminish the vascularity of the parts. Wait five minutes then inject one-half drachm of warm sterilized olive oil, and there will be plenty of the lubricant at the tip of the instrument. If great difficulty is experienced in passing even the filiform, pass over this a small tunneled catheter, remove the filiform, and leave the catheter in for twenty-four hours, after which gradual dilation can be continued. In case it is impossible to introduce the tunneled catheter leave the filiform for twenty-four hours when there will be a marked relaxation of the stricture. Sometimes if a medium sized sound is held firmly against the strictural obstruction for a minute or two, it will relax sufficiently to allow a filiform to pass. The urethroscope is sometimes a valuable aid in finding the strictural opening.

It is well to bear in mind the complications that may attend the passage of sounds. If the patient is of a neurotic temperament, he may become collapsed from the shock. This may be avoided by the injection of a few drops of a 4 per cent solution of cocain into the urethra. When it occurs give thirty drops of the arom. spirits of ammon. and keep the patient in bed for the rest of the day. If the patient be plethoric and has been eating and drinking to excess, the mucous membrane may be extremely congested, and even a soft instrument may cause bleeding without serious damage to the parts. This can be prevented by keeping the patient in bed for a few days previous to the instrumentation, allowing him only a light diet and producing free catharsis with salines. The injection of a few drops of adrenalin solution will be of service in these cases.

The passage of a sound sometimes produces a condition known as urethral fever or catheter fever. The severity of this condition varies from a slight rigor to a distinct chill followed by fever and the usual symptoms of acute sepsis. It may pass off in a few hours or it may incapacitate the patient for several days, or it may prove to be a very serious and dangerous complication. The milder forms are said to be due to the contact of the instrument with the prostatic portion of the urethra, and that it can be avoided by introducing the instrument no farther than the strictures. As a prophylactic treatment it is well to keep the patient in bed for twelve to twenty-four hours before the time of instrumentation, and give gr. x of quinin, sulph. with ten drops of the tincture of aconite one-half hour prior to treatment.

As has been mentioned above, false passages in the urethra may be made with a sound. This however, will not occur if the operator will bear in mind that no force is to be used in the introduction of any instrument into the urethra.

Epididymitis may, but seldom does follow the passage of a sound.

When the stricture is very tight and there is a severe cystitis present, it is best to give a general anesthetic, dilate sufficiently to introduce a catheter and fasten it in for twenty-four to thirty-six hours. This insures drainage and allows irrigation of the bladder with a saturated solution of boric acid, or ½ to 1 per cent solution of nitrate of silver. Do not leave the catheter in more than forty-eight hours without removal, as it may cause severe and serious urethral infection, also periurethral infection which may be followed by urethral fistula, or prostatic abscess. After a catheter has remained in the urethra for twenty-four to forty-eight hours there is but little difficulty in further dilating with the sounds.

Internal urethrotomy is not to be recommended except in the hands of those skilled in genito-urinary surgery, because of the obscurity of the field of operation, and the possibility of doing great damage. The cavernous spaces may be opened, producing a very free hemorrhage, which is sometimes almost uncontrollable.

The indications for perineal section are few, in the treatment of stricture. The most imperative is stricture due to trauma. Early operation in traumatic strictures is usually followed by premanently good results. It is astonishing how much of the urethral mucous membrane will be restored

after the excision of the fibrous tissue of a stricture.

The irritable resillient stricture in the bulbo-membranous region, in which every attempt at instrumentation causes severe pain, urethral spasm, subsequent tenesmus, and possibly chill and fever, requires an external urethrotomy, with free division of the fibrous bands. Multiple strictures of small calibre of long standing may not yield to dilatation, and should be cut through by means of an external incision before perirurethral abscess and fistula form. Strictures complicated by fistula and severe cystitis should be treated by perineal section after dilatation and irrigation have proved inefficient.

In some cases of sudden and complete retention of urine due to acute congestion of the mucous membrane over stricture bands it is very difficult and at times impossible to enter the bladder per urethram. Never give a patient suffering from such a condition a general anesthetic as his struggles may cause rupture of the over-distended bladder. A trocar can easily be introduced above the pubes and the tension relieved after which it is sometimes very easy to reach the bladder per urethram. If not the patient can now take a general anesthetic without danger of rupture of the bladder, and a perineal drain established if necessary.

The points I wish to emphasize are:

1. That almost every stricture which is secondary to specific urethritis, is amenable to gradual intermittent dilation treatment.
2. That the strictest asepsis should be observed in the treatment of urethral strictures.
3. That the small metal sound is a dangerous instrument.
4. That the first principle to be observed in the introduction of any instrument into the urethra is that no force is to be employed.
5. That internal urethrotomy is unsafe and should never be attempted by the unskilled and inexperienced.
6. That external urethrotomy is very seldom indicated in other than traumatic strictures.

Infected Dwellings the Cause.—Study and experience have brought me to the conviction that pulmonary tuberculosis may, for all practical purposes, be considered to be always due to exposure for a considerable length of time, in a house that harbors or has harbored a human consumptive.—Dr. B. M. Randolph.

FORESHADOWING OF DEMOCRACY IN THE A. M. A.

G. FRANK LYDSTON, M. D.

CHICAGO.

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The recent action of the Council of the Chicago Medical Society endorsing by a series of resolutions certain suggestions of reform in the A. M. A. for which I have been long contending, marked the beginning of the end of close corporation methods and of despotism in the A. M. A. It is noteworthy that the majority vote by which the resolutions were adopted was fairly representative of the sentiments and wishes of the rank and file of the membership of the Chicago Medical Society. The rank and file have long been restless under the dominance of self-elected so-called leaders, whose psychology has been overshadowed by the fatuous motion that they are the Lord's anointed and made of clay different from that of the practitioner whose sole function in the eyes of the self-perpetuating machine is to pay dues and furnish consultation fees to the elect.

The "line up" in the voting showed that the faction which opposed reform was composed mainly of integral parts of the machine, their beneficiaries and satellites, who were seeking for crumbs from the machine table. Some of these satellites were grateful for past favors, others showed a lively appreciation of possible future favors. None, I fancy, could have offered a better reason for opposing reform than the threatened disturbance of the established order of things—which order has been of exceedingly great personal interest to the anti-reform leaders.

The spectacle of a councillor who is also chairman of the Board of Trustees, delegate to the Illinois State Society and delegate to the A.M.A., and of another councillor who is assistant secretary of the A. M.A.—a paid employe of the Association—opposing the reform resolutions, should alone have been sufficient to convince any fair-minded, thinking American citizen that reform is urgently needed. Members of the local and state societies who believe in autonomy for their organization would do well to ponder on this marvellous exhibition of self-interest in medical politics.

The most urgent duty of the A. M. A. is to provide for elections by A. M. A. membership ballot. The present method of election of delegates is a farce which no other body of American citizens would for a moment tolerate. I question whether

there has been an election in the A.M.A. since its reorganization which could be fairly termed legal. The legality of elections in American politics revolves around the qualifications of the voting unit—in the case of the A.M.A., this unit is the individual member. According to the present system this unit may or may not be members of the A. M. A. Note the following, please:

Membership in the A. M. A. demands membership in a local and state society Membership in the local and state society, however, does not necessitate membership in the A.M.A. Tracing the elections for the members of the official body of the A.M.A. back to the individual voting units, therefore, we find that members and non-members of the A. M. A. especially enjoy the elective franchise; especially is this true of "affiliated" societies, of which more anon.

Dr. A. belongs to the A.M.A. and therefore to the local and state societies, while Dr. B. belongs only to the latter bodies. We find A. and B. voting side by side, first, for councillor to the local body, second, for delegates to the State society, third, for delegates to the National body. The latter, therefore, represents—theoretically, at least—the will of both members and non-members of the A. M. A. A. pays ten dollars per year for his voting privilege, or ,rather he did pay ten dollars per year prior to the recent separation, as an expediency and machine protective measure, of A. M. A. membership from the Journal subscription. Even with this separation, there is an extra tax on the A. M. A. member. B. pays, in the Chicago Medical Society, only five dollars per year. There is no provision in the constitution and by-laws of the A.M. A. that non-members of the A. M. A. shall not vote in the constituent bodies. Such a provision would "bust" the machine. Such coercion would not for a moment be endured by the rank and file.

Members of affiliated bodies who are not even members of their local society have the elective franchise and vote for councillors in the latter organization. Certain affiliated societies, I believe, provide in their by-laws that applicants for membership must be members of their local society, but do not take the voting power away from members who have dissociated themselves from the local body. As I see it, the situation is anomalous and one that can be remedied only by one or the other of the following procedures:

1st. Membership in the A. M.A. must be made compulsory for members of the local and State societies, or

2d. Elections in the National Association must be by A.M.A. membership ballot, the representatives of state societies being delegates ex officio, without a voice in the management of the A. M. A.

The profession would not stand for the plan first mentioned, hence the second is the only way to a fair and logical political arrangement.

The average A.M.A. member is a long way from the official body of the A.M.A. and cares very little for what happens there, while as for the non-member, he cares not a straw for anything that transpires beyond his local or, at most, beyond his state, society. Few men, whether members or non-members, realize when they vote in the constitutent bodies, that they are supposed to be voting in theA.M.A. Their indifference to what is occurring at headquarters therefore, is but natural. That they are often swayed hither and yon by little coteries of self-seeking machine politicians is still more natural. That the machine coterie of self-seeking medical politicians should be self-perpetuating, running on and like Tennyson's Brook, should surprise no one who knows human nature.

One of the most absurd features of local medical politics—one, too, which is an uncomplimentary reflection on the intelligence of medical men—is the present system of affiliation of special societies. For example, we have in Chicago such organizations as the ophthalmologic, pediatric, gynecologic, pathologic, orthopedic, surgical and other special societies—ten in all. These are "affiliated" with the Chicago Medical Society and represented by councillors who vote side by side with the regular councillors of the society. As the majority of the members of these affilliated societies are also members of the Chicago Medical Society, it will be observed that a member may vote as many times as his various memberships will permit.

If, for political, "business" or scientific purposes he cares to join all the special societies, he is privileged to vote twelve times for councillors to the Chicago Medical Society, for he votes for councillor in his branch and also for councillor at large—which means he has twelve votes in A.M.A. politics!

How does this strike the brother who cannot or does not belong to any of the special societies? When will he wake up? A certain officer of the A.M.A. is credited with membership in five local special societies. Seven votes for himself, therefore. As he is a councillor and also a State dele-

gate, he has two more voting chances, making nine in all.

Again I ask, is it strange that the political machine of the A. M. A. is both selfish and self-perpetuating? If the members of the A.M.A. cannot see the point, the case is indeed hopeless, merely because doctors must have a different ethical and moral standard from that accepted by decent citizens in general.

One of the crying evils of the present regime in the A. M. A. is the despotic manner in which members who move their residence are forced to either join the local society in their new locality or get out of the A.M.A. A case in point is that of Dr. Howard Crutcher, of Roswell, New Mexico. This gentleman, a member in good standing of the A. M. A., the Chicago Medical Society and the Illinois State Society, was dropped from the list of members in the A. M. A. directory because he did not join the Chaves County Society. He would not join if he could and could not if he would. This gentleman has a fine case at law against the A.M.A. and its secretary general-editor-manager, which, it is to be hoped, he will push to the bitter end.

Once our pocketbook is touched, then will be action among the medical crustaceous, pachyderma and victims of sleeping sickness, and Association reform and discipline of tyrants will surely follow.

If it be compulsory to join the new local society, a transfer card which makes it mandatory for the aforesaid society to receive the stranger as a member should be provided for. There is nothing in the by-laws which makes it mandatory for a member who changes his residence to join the local society in his new location. But this is no impediment to the wonder-working machine. What are, in effect, by-laws for temporary use and membership rules to fit selected cases are made while you wait. I fancy the details of the Crutcher case will be published later by the victim of the outrage; if not, I myself probably shall take a hand in the game. The case at present is in the hands of the Ethical Relations Committee of the Chicago Medical Society. The profession may rest assured that this committee will render a verdict untrammeled by machine influence, and that no machine whitewash will gloss over the facts of what seems at this writing to be an outrage as glaring as that inflicted by the machine on Dr. Henry B. Young—whose case I have reported in detail in my pamphlet, "The Russianizing of American Medicine and the Medical Dreyfus."

I might remark in passing that the graduation key to Dr. Crutcher's name in the old directory seems to be meaningless hieroglyphs. His old, since renounced, sectarian school is given in the new directory, while his graduation from the medical department of the Illinois State University is not mentioned. Really, t'will be a pity if he does not hire a good lawyer and throw his case into the Federal court. I fancy, too, that the postoffice authorities might logically take a hand in the case. Dr. Crutcher's statements of membership dues in the A.M.A. have been mailed to him regularly and the dues have been paid. Has the despotic management of the A. M. A. been using the mails to defraud? Heaven forfend!

Reverting to the question of autonomy in the local and state societies, the membership at large must derive cold comfort and little pride or self-respect from existing conditions. The subsidiary societies are merely kitchens in which the politics of the A.M.A. are "cooked up." In most local councils and state societies, officials of the A.M.A. dominated. This is especially pertinent as applied to the Chicago and Illinois State societies. The treasurer of the A.M.A. is a delegate to both the State and National associations, and at the meeting of the State society in 1909, dominated its politics. Another of the leading officers and machine workers of the A.M.A. served last year as councillor, state delegate and national delegate. This gentleman was chief "whipper in" for the machine crowd in the State meeting of 1909.

The chairman of the Board of Trustees of the A.M.A. is a councillor in the Chicago Medical Society, delegate to the State society and of course a delegate to the A. M.A. A number of other men serving as councillors in the Chicago Medical Society and delegates to the Illinois State Society, hold official jobs in the A. M. A. I have elsewhere noted the case of the assistant secretary—associate editor of the A. M. A. —an earnest worker in the field of machine politics—who is a councillor in the Chicago Medical Society, and also a delegate to the State society. This gentleman has been selected by the machine for the position of secretary-general in case reactionary association sentiment should force the ring to displace the accomplished gentleman who now holds down three jobs. As I have elsewhere remarked, this forced sop to the Cerberus of membership discontent would result merely in a change of names and not of msaters. The assurance of these gentlemen is equalled only by the density and indifference of the members who have allowed

such a burlesque to be made for local and state society politics. I blame the latter more than I do those who have taken advantage of their weakness. Indeed, I sometimes become discouraged in fighting for men who will not fight for themselves, and think, "what's the use trying to be a political eye specialist?"

An addition which might with advantage have been made to the Chicago Medical Society's resolutions is the suggestion of a provision for either an itemized yearly account of the business of the A. M. A., or, if this plan should be found to be impracticable, the yearly appointment of a special non-official committee to examine and report upon the business affairs of the association. Some plan certainly should be provided by which the membership of the A. M.A. would be taken more intimately into the confidence of the official body. This would do much to allay the present natural unrest among the rank and file. Another reform, the suggestion of which would have been popular with those who believe in conducting the association along purely democratic lines, is the nomination by petition of candidates for various high offices. This, if adopted, would relieve the annual elections of their present "cut and dried" quality. It works well in the Chicago Medical Society, why not in the A. M. A.?

This much may be said of the physician, viz.: Impractical though he may be in the everyday affairs of life, he has deep down in his heart as much American pride of citizenship as has the average man. This being true, the majority of officially disinterested members of the A.M.A. must needs in self-respect and regard for their individual rights demand reform in the organization.

Apropos of democracy, I would call attention to the big "I" custom of entertaining visiting phyiscians by medical societies. Most often the distinguished visitor—who is attending the society and reading a paper on the invitation and at the expense of the organization—is taken in tow by a few self-appointed machine devotees of "publicity and promotion." Dinners are given to the select few, and the visitor thus debarred from meeting more than a small proportion of the membership, who in turn are debarred from meeting him—a distinct loss on both sides. In Chicago, a very unique method of getting the glory without "paying the piper" has been tried. A machine man has taken the visitor in tow and announced that he was giving a dinner in honor of the distinguished Dr. Fizz, etc., etc. A few men have been invited—but asked to pay for their own plates. The munificent host of course paid for the guest's plate, but with characteristic modesty failed to notify the press of his generosity. Several stunts of this kind have been pulled off in Chicago of late. But we have begun to "sit up and take notice." The last "cheap skate" politician who tried to put through a scheme of this kind, was caught red-handed in time to change plans and the society itself took charge of the subscription dinner.

Hereafter, the members at large will be invited to such affairs. If they are good enough to send consultation fees to the leaders, pay dues and furnish auditors for our distinguished visitors, they are good enough to meet them socially.

The dawn of a new and more democratic era is breaking—let the day be glorious. Let the various local and state societies pass reform resolutions modelled after those just passed by the Chicago Medical Society—incorporating therewith a demand for A. M.A. membership ballot and for two additional local trustees—and thus demonstrate that the profession is arousing from its sleeping sickness. Results will soon follow. The A.M.A. machine will be overthrown and a just, fair and democratic regime will take its place.

One thing is certain, viz: Reform and reform alone will save the A.M.A. from disintegration. Thousands upon thousands of thinking men are ready to flock to a new standard. That standard will surely be raised if reform does not come. There are men in this country who love the A.M.A. for what it was, whose hearts have ached to see it sink in the stew of machine politics, and who would, if need be, lead in the organization of a new and better association. What shall it be, reform or a competing national association? "Under which king, Bezonian"

The Alienist and Neurologist for February, 1910, contains the following original articles by prominent writers: The Insane—Dr. Turner's Life and Work—Is Genius a Sport, a Neurosis, or a Child Potentiality Developed—Hazing Psychopathy—Scope of Developmental Pathology—The Emmanual Movement and its Affinities—Transplantation of the Spinal Ganglion into the Brain—Neuro-Rectal and Recto-Neural Relations in Surgery—Notes on the History of Psychiatry, and many others, including an excellent number of selections, besides the usual number of editorials, reviews, etc.

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EDITORIAL

A New Danger in Dying.

It is getting quite the fashion these days for relatives or friends of a lately deceased individual to institute proceedings to secure a belated post-mortem and to establish some violent or unnatural cause as being responsible for the exit. The newspapers have, for the past month, been so filled with stories and suggestions along this line that we look for nothing else than a tremendously increased number of reported poisonings in the very early future. The St. Louis husband, the Kansas City mililonaire and the Columbia professor may have met death as a result of poison administered by other than themselves, if so we are profoundly hopeful that the crimes will be speedily and quietly fixed on the parties responsible for them, but we are not at all certain that it would not be better to have allowed these to go unavenged rather than to have caused all this agitation and the implantation in the mind of a hysterical public of the erroneous idea that male and female Borgias are everywhere and are constantly doing their evil work. Already, since this agitation is under way, a poor demented woman has died in our city asylum, two or three days before her death her husband had visited her and had brought her some prune sauce which she was allowed to eat. Dying suddenly a very complete and pretty line of events led to a problem of tragic possibilities. Of course there had to be an autopsy, and all that and with the autopsy newspaper interest relegated the affair to a remote few lines, for the woamn died of natural causes. But what can ever recompense the husband for those few days of intense agony and apprehension? What will ever counteract the fear which this story has helped to fix in the minds of many, the fear of being poisoned?

Of course there is no getting away from the findings of an expert in his laboratory, but in spite of these findings and with the evidence of poison in the body it does not of necessity mean murder. Many people use various of the poisons habitually, notably morphine, strychnine and arsenic; they establish something of a tolerance, and at the same time they lose their fear of the drug which they are using and employ it in excessive dosage; is a wife, a son, a daughter, a friend to be accused of murder because the drug is detected after death. People who employ these drugs are secretive about it, and as things are now going there will be troublous times ahead for many innocent people if some halt is not called in the freedom with which suspicious are spoken or insinuated.

We believe that murder of all kinds is rare, fortunately so; and we believe that poison is rarely used as an agent. That there should be several cases at this one time, and in this one state under investigation is a far-reaching misfortune, whatever the findings, whether affirmative or negative an evil is being done which will be years in being overcome.

The "Get-Together Meeting of the St. Louis Medical Society.

The last January meeting of the St. Louis Medical Society was purposed by the administration to stir up enthusiasm for the year's work, and it was, in a high degree, successful. That the fates should have brought Dr. J. H. Honan, of Berlin and Nauheim to St. Louis at any time is to our advantage, but that his only only chance to address a large medical body should have been at a meeting of this kind was unfortunate. Had the doctor chosen to speak of the Anglo-American Medical Association of Berlin, of which he is president, it would have been more in keeping with the general purpose of the meeting; but an address on the Nauheim baths with more or less tedious detail as to methods might have been welcome on another occasion, but was distinctly disappointing at the time.

With this exception the program prepared was to the point. Dr. J. C. Morfit spoke for the St. Louis Medical Society and its aspirations; Dr. F. J. Lutz, of the Missouri State Association with especial attention to its relation to the county bodies, its general aims and its relation to the National Association; Dr.W. B. Dorsett, of the American Medical Association itself. Each address was excellent. We have often wondered

why so many good proverbs are allowed to get a distorted meaning, and we could not help catching something of the kind drifting through these addresses. We are all supposed to be aiming at the general uplift, and if none of us will cultivate any but our betters, it is all very well to say that "a man is known by the company he keeps." But a man may be able, honest, upright and so filled with the importance of influence on others that he will associate much with those who are not exactly in the shadow of the holy-of-holies and be a great man for the fact. There is yet to be found a perfect medical society, or a perfect medical school; the best of today, as they were a decade or more ago, could not compare with the weaklings of today, the weaklings of today may be the giants of a decade hence. That there are able, energetic, self-sacrificing men who associate themselves with enterprises which are struggling against odds, but which promise to become powers for good is fortunate, these men are more worthy of encouraging approval than of implied or covered censure.

But we are wandering from our text.

After the addresses the meeting adjourned to an informal smoker in the parlors, where light refreshments were served, and a most enjoyable hour spent. This feature of these meetings is very important, and is doing much to make the local profession a unit. We are glad to learn that something of the kind is to be on the program for each fifth Saturday in the month during the year.

St. Louis Society is starting 1910 in a most aggressive manner, and it is already evident is be one of remarkable accomplishment.

Local Anesthesia in Major Operative Work.

There are many practitioners who have still to learn how serviceable local anesthesia (hypodermic) is in many of the cases for which they now employ chloroform or ether; it would seem little less than a serious reflection on the progressiveness of a physician that he should acknowledge that he employs general anesthesia for a circumcision in an adult case, yet we are constantly hearing of it being done. But the lesser anesthetic methods are gaining a wider field, and we are hearing of considerable operative undretakings accomplished under the protection of this method. Speaking of local anesthesia in major work Hasbrouck* says local anesthesia in major operative work has been made possible by our more perfect knowledge of the action of cocaine when in combination with that great hemostatic—adrenalin chloride. His own work for two years past has been done with tablets prepared by Parke, Davis & Co., after the formula of Braun. Each tablet contains cocaine ¾ grain; adrenalin chloride 1-400 gr. These are sterilized by dry heat for an hour three on successive days and keep indefintely. One of these tablets dissolved in 12 drachms of normal salt solution, gives a solution of known definite strength of approximately 1-1000 or 1-10 of 1 per cent. One tablet dissolved in 2 drachms makes a 1 per cent solution, and these are the only two solutions necessary. The two methods of use are ordinary infiltration and nerve blocking. For the former the weaker solution is used; for the latter the stronger. The technic is as follows: Precede the operation with ¼ gr. morphine hypodermically. All of the preliminary work and most of the subsequent work will be done with the weaker solution, 1-1000, and the first step is that of skin infiltration for the initial incision. For this purpose two or more hypodermic syringes are kept busy, the empty ones being filled, while the other is in use. Remembering that our solution is non-toxic we use it freely along the entire line of incision, just barely beneath the skin, producing a wheal ahead of us as we advance, and then deeply kneading the tissues so as to disseminate the fluid. On cutting down we will find the tissues blanched and bloodless and entirely without sensa tion. On reaching the deeper structures knowledge of nerve distinction becomes of prime importance, for by availing ourselves of Crile's method of nerve blocking, the sensory nerves are picked up, one by one, and injected with a few minims of 1 per cent solution, after which the entire field becomes insensible to touch. If at any time a sensitive part is encountered a few injections with the weaker solution is all that is necessary to render it insensible; and thus feeling our way along the work is brought to a successful and painless close. The scope of this method, generally speaking, includes all operations were the entire field can be made anesthetic. It is not, of course, suitable for very young chilrden or hysterical people.

Cleansing the nostrils and fauces in scarlet fever, measles, tonsillitis, acute coryza, etc., is of prime importance.

* Virginia Medical Semi-Monthly, September, 1909.

The Relation of the Profession to Morphinism.

In a paper recently read before the Jackson County (Mo.) Medical Society at Kansas City, Dr. S. Grover Burnett brought out some points which are tremendously surprising and of vital interest to the profession. He showed 90 per cent of addicts closely associated with the profession, viz.:

Physicians	50%
Physicians' wives and widows	20%
Nurses	10%
Druggists	6%
Dentists	4%
Laymen	10%

Based on 100 unselected cases.

American statistics show 200,000 addicts in the United States. European statistics show 75 per cent of addicts are medical men and that 20 per cent of the mortality among medical men is due to morphino-mania;that the profession in England is notoriously indifferent to the subject. Dr. Burnett showed how medical indifference and commercialism creates affilial quackery;how the quack cures see the necessity of switching their advertisements to the profession to make soliciting agents of a certain class of medical men for a rebate per cent—debauching the profession and debauching the already debauched; how unethical it is to permit agents to canvass our offices for quack institutions, practicing secret methods, publishing testimonials and paying secret rebates.

Dr. Burnett contends morphinism is a physical disease; that medical indifference is not tenable on the grounds of it being a moral disease; that paralysis of mind function presiding over moral and will force is a sequel of morphinism; that simple morphinism is due to the stress and accidents of the modern civilization and the higher the quality types of brain addicted the greater the intrinsic damage done.

Dr. Burnett puts the addicts into three divisions, viz.:

1. Simple morphinism.
2. Morphino-mania.
3. Motiveless or delusional morphinism.

Clinical illustrative pictures were given of each type.

SUMMARY OF DIVISIONS.

In simple morphinism there was exhausted nerve energy, inherent or acquired. The drug was taken to relieve physical and exhaustive nerve discomforts.

Morphino-manias are lower in intellectual stability. Inherited weakness of nerve and mind energy is the rule and the predisposition to acquire exhaustive states is strong. The drug is taken to relieve exhaustive psychic pain, mind pain, mind discomforts. The drug further deteriorates a mind already near the borderline.

Motiveless or delusional morphinists are over the border line and take the drug because of a faulty mind state. It is apt to end in a terminal depressive insanity.

How morphinism becomes organic disease was of interest; first, a reversal of the normal alkalinity of the ganglionic cell to the pathologic acid polarization of the cell; second, the continued acidity resulting in intra cellular molecular changes; and third, a final chromotolysis or a breaking up of the cell in its histo-anatomical make up and loss of its function.

Dr. Burnett regarded the asylum confining and immediate stopping of the drug as unscientific and only practiced under compulsion of the circumstances or by those of little or no practical experience; by those without knowledge of the underlying pathology to be repaired and by those who see nothing but a habit to be broken and to whom it does not occur that they should treat the patient and not the habit.

ST. LOUIS ITEMS.

Dr. J. T. Dixon, of Providence, Kentucky, is frequently in St. Louis these days. It is reported that he will either locate here or take a part of St. Louis to Kentucky at an early date. The latter is the more probable.

Dr. Henry R. Harrower, who has been a frequent contributor to the original department of the Fortnightly, has become editor of the Medical Standard of Chicago. The Medical Standard has established a record for intelligent aggressiveness and practical usefulness which we believe Editor Harrower is capable of developing to even greater usefulness.

Death of Dr. Andrew Harscher.—Death has again invaded the ranks of the St. Louis profession. Dr. Andrew Harscher died at his home on South Grand Avenue on the evening of January 26th, the nature of his fatal illness has not reached us. Dr. Harscher was born in Beardstown, Ill., in 1866; he took his medical course at the old Missouri graduating in 1896. Since his graudation he has been continuously in practice in this city. The St. Louis Medical Society, of which he was a member, has sent messages of sympathy to his widow, Louise Ludwig Harscher, and further tribute to his memory will be made at the memorial meeting in May.

Dr. T. G.Atkinson, formerly of Chicago and promniently connected with medico-literary affairs, has removed to St. Louis and has become editor of the Medical Brief. During recent years the Brief has assumed a position of increased importance as judged by its fellows, its editor for the past two years has given it a scientific cast which it had never before enjoyed. Dr. Atkinson will keep up this standard and make it more actively felt in other medical interests.

Dr. Frank Parsons Norbury, president of the Mississippi Valley Medical Association and superintendent of the Illinois State Hospital at Kankakee, will deliver the address in Medicine at the meeting of the Medical Society of the Missouri Valley, at Omaha in March.

According to United States consular reports, the tuberculosis death rate is twice as large in Syria and Turkey as it is in the United States. There is only one special hospital for this disease in the entire Ottoman Empire.

To Our New Subscribers.—Dr. Eccles' interesting series "Touring the Lands where Medical Science Evolved" has not been completed. There are two or more installments to follow. When these have been published, the letters will be bound together in one volume and a copy mailed to each one entitled to receive same.

For Medical Research.—Mr. Otto Beit, the South Artican millionaire, has made a gift of $825,000 to the London University for use in medical research. Mr. Alfred Beit, late brother of the donor, recently bequeathed $250,000 to the same institution, making a total of $1,075,000, the income of which is to be devoted to providing ten fellowships of the annual value of $1,-250.

Chinese Surgery.—Medical missionaries in China say that the natives will bear without flinching a degree of pain from which the stoutest of us would shrink in terror. A woman in Shao-wu, afflicted with a ulcer of the leg was treated by a native "doctor." One day he came to the mission hospital to show the physician in charge a "string" which he calmly announced he had pulled from the wound. It was the sciatic nerve! To people suffering from such barbarous methods, and to whom anesthetics are unknown, the merciful methods of foreign doctors in the mission hospitals seem like miracles.—Jour.A. M.A.

THE REVIEWER'S TABLE

Books, Reprints, and Instruments for this department, should be sent to the Managing Editor, Century Building, St. Louis.

Song and Story from Les Chenaux. Vacation Memories. By Dr. Wm. Porter. Being a collecting of poems and other writings of the author. Published by the author. St. Louis.

We must confess that we had never expected to be called upon to assume the role of critic of poetry; at another's reading we have been able to appreciate the beauty of that style of literature, but our own reading makes the most noble masterpiece the veriest doggerel. But we can, nevertheless, see the sun-kissed lakes, the breeze stirred trees and the shadow-mapped landscape as we read these poems from Dr. Porter and we realize that the world is good and that the greatest power in it is Love. Another might not catch it were we reading the poems aloud, but it is there. The prose selections of the book are characterized by a keen insight and a remarkable fund of humor, though not strictly medical there are few of them which will not appeal to the medical mind and prove interesting and diverting.

There is nothing in the volume to indicate that it is on the market, it appears to be purposed only for distribution among the author's friends, but we could wish that it might reach many of our friends for its influence is for the good, and its aim is toward the up lift for which we are all striving.

A Practical Treatise on Diseases of the Skin. For the Use of Students and Practitioners. By J. Nevins Hyde, A.M., M. D., Professor of Dermatology and Venereal Diseases in the University of Chicago, Medical Department (Rush Medical College). New (8th) edition, thoroughly revised and much enlarged. In one very handsome octavo volume of about 1137 pages, with 528 engravings and 58 full-page plates, in colors and monochrome. Philadelphia and New York: Lea & Febiger, 1909. (Cloth, $5.00, net; leather, $6.00, net.)

When a work has passed through its original edition and seven successive revisions are demanded, its acceptance by the public as a standard is beyond question. Professor Hyde's masterly treatise exemplifies this statement. One of the foremost dermatologists in the world, and an equally successful teacher, he knows both his subject and how to present it effectively, both for the student and practitioner as well as for the specialist. Each of the prior revisions brought the work thoroughly abreast of its date, but never before has it been subjected to such a complete rewriting. Every line has been carefully revised with a view to possible improvement, everything that progress has discarded is omitted, and the real

advances are incorporated, so that the possessor of this new edition has the net dermatology of today at command. As an indication of this it may be stated that changes and improvements have resulted in an increase of two hundred and fifty pages, and that the engravings and plates have been doubled, new photographs being substituted whenever a disease could be better displayed to the eye. It is risking nothing to predict for this admirable work in its new form, even greater favor than it has hitherto enjoyed with all classes of readers interested in dermatology.

The Physician's Account Book. By J. J. Taylor, M. D. Bound in full leather; 24 pages of practical instructions for physicians, 216 pages of accounts. Philadelphia, Pa.: The Medical Council, 4105 Walnut St. (Price $1 per copy.)

This book is without a doubt the most complete and at the same time simple and thoroughly efficient account book that has ever been devised. Furthermore, it is absolutely legal and can be presented in any court of justice. It does not make use of any hieroglyphics, but everything is entered in plain language, and any judge can understand it.

The book contains 24 pages of business instructions for physicians, which have been found very useful and correct in a long and varied practice, under the headings of "Importance of a due bill," "Fees," "Billing and collecting," "Cautions," "Statute of limitations," "Forms for wills," "Dying declarations," "Saving and investing," "Instant treatment of poisoning," etc. It also contains an average fee bill which has been found to work out correctly in practice.

This book contains 216 pages for accounts, of which eight pages are devoted to alphabetic index, 146 pages are devoted to regular accounts, 32 pages to short accounts, 24 pages to cash accounts, and eight pages to birth, death, and vaccination records.

This book has the advantage that entries can be made in a fraction of a minute, right upon the spot, thus insuring that none will be omitted on account of procrastination. The book being always in the physician's pocket, it is always up to date, never requiring any posting, and when he meets a debtor on the road who inquires about his account, he can inform him at a moment's notice and thus collect what the debtor has to pay at that time, instead of puting off an answer until some convenient season and thus missing that payment.

This book is so convenient, useful and legal that an eminent Philadelphia judge, who has tried hundreds of cases in which physicians' accounts were involved has stated that "In the light of my recent examination of the law, I can say that the form of book which you have gotten together is as convenient and accurate as could well be devised."

Progressive Medicine, Vol. IV, December, 1909. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 334 pages, with 35 engravings and a colored plate. Philadelphia and New York: Lea & Febiger, Publishers. (Per annum, in four-bound volumes, containing over 1,200 pages, $6.00, net; in cloth, $9.00, net.)

The December issue of Progressive Medicine is fully abreast of the reputation of this quarterly for practical usefulness to every active medical man, whether physician, surgeon or specialist. In fact, its contents are purposely limited to the clinical as distinguished from the theoretical aspects of medicine. As brief examples of these characteristics, we may cite only a few of the multitude of topics treated by Dr. Edsall, of Philadelphia, in his 90 pages on Diseases of the Digestive Tract, one of the most important in the entire range of human ailments. He discusses the value of the Salomen test in establishing a diagnosis of gastric disease, especially of carcinoma of the stomach; the effects of drugs on peptic digestion, the influence of intestinal derangements, menstruation, pregnancy, and pelvic disease on the digestive organs; acute intestinal gastritis; gastric ulcer, etc., etc. Then the latest researches in diseases of the intestines, of the liver, and of the pancreas, are considered with equal conciseness and thoroughness. In the same brief manner we may refer to articles on Orthostatic Albuminuria and the X-rays and Renal Cacluli in the section on the Kidneys, written by Dr. John Rose Bradford, of London. Bloodgood, of Baltimore, has covered the real additions to practical surgery during the year. His remarks on surgical shock deal instructively with a common and serious condition. His article on new methods of inducing anesthesia covers a subject of especial interest at this time; and his discussion of fractures and dislocations is one which should be of great value to all general practitioners as well as surgeons. He closes with forty pages on tumors, thus completing in connection with his successive sections on these morbid growths, the most important monograph on the subject in the language. Belfield, of Chicago, covers the latest advances in the genito-urin-

ary field authoritatively in 30 pages. The assistant editor, Dr. Landis, closes the year with a Practical Therapeutic Referendum, reviewing the advances in both medicinal and non-medicinal treatment.

Progressive Medicine occupies a unique position by reason of the fact that it is a high authority on each line describes all advances in his own language. It is wholly original, easy and interesting to read, and instructive on just the points the medical man most values, namely, those necessary to bring his own knowledge to date. The writers have the latest medical literature of all civilized countries at command, hence the reader can get in these pages what he could neither find elswehere nor gather for himself, namely, a concise statement of the latest developments in the whole world of medicine.

This is the first portrait to be published of Frances Little (Mrs. Fannie C. Macaulay) of Louisville. Ky., author of "The Lady of the Decoration," now in its twenty-fourth edition and of "Little Sister Snow," published recently.

Echinacea is especially useful in all conditions in which a tendency to sepsis is a prominent characteristic, regardless of the name or location of the disease.

Insomnia is often caused by an overfilled and dilated stomach, be it with fluid, air, or both. To empty this gives grateful relief and is often followed by instant sleep. —J. Madison Taylor.

MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

GENITO-URINARY.

T. A. HOPKINS, M D.

A Case of Sarcoma of the Kidney.—In Post-Graduate for November, 1909, Dr. Albert S. Harden gives the history of a case of sarcoma of the kidney in a child 2 years and 3 months old. Age is an important factor in malignant growths of the kidney. Out of a total of 647 cases obtained from different soruces, we find 464, or approximately 72 per cent, occurring during the first five years of life. Sex plays but a minor part in these growths, as they seem to occur with equal frequency in both sexes. As a rule, small round-cell sarcomata are small, non-encapsulated tumors, which on section appear very similar to brain tissue and are usually quite friable. On scraping the cut tumor a milky substance exudes, and on continued scraping the entire tumor may be scraped away. On section the tumor is white or grayish-white in color. On microscopic section the tumor is found to be made up of spherical cells which contain a vesicular nucleus, staining deeply with hematoxylin. The cytoplasm of the cell, however, takes the stain poorly and at times is very difficult to demonstrate. The intercellular fibrillae also are difficult to see, as the cells are so close together that they seem to be held together by cohesion. The most important symptoms of sarcoma of the kidney are cachexia, tumor and hematuria. Of these the most important is tumor,in that it is generally the first thing discovered. Cachexia occurs rather late in the disease. Hematuria occurs in about 25 per cent of the cases, and in the majority of these in only microscopic amount, although it may be appreciable to the naked eye. These tumors grow very rapidly death occurring within from three to nine months after the diagnosis has been made unless surgical intervention is resorted to. Cases of enormous growth of these tumors are on record. Jacobi reports one weighing 36 lbs; and Morris mentions a case in which the tumor weighed 31 lbs. The prognosis is very grave, although the mortality in renal surgery has been greatly reduced in the past few years. Keuster places the mortality at 25 per cent for nephrectomies for malignant disease, while Schmeiden give 32 per cent out of a series of 329 cases.

Nephroureterectomy.—J. W. Bovee, Washington, D. C. (Jour. A.M.A., October

23), gives histories of four patients operated on by the following method, which he claims markedly reduces the duration and traumatism of the operation and facilitates to a remarkable extent liberation of the lower portion of the ureter, provides simple and dependent drainage, permits removal of the kidney and ureter in one piece, allows closure of the wound except when much pus is spilled, does not exhaust the patient, and simplifies the preparatory measures. It does not, he claims, require special apparatus for the detection of the lower end of the ureter or for its exposure and liberation. The operation is described substantially as follows: The patient is put on the table in the Simon position and the loin area prepared for operation. The preparation of the perineum, vulva, pubes, and vagina is made as for any vaginal operation. The anterior vaginal wall is next exposed and a vulsellum grasps and pulls the cervix downward to locate the interureteric ligament. On the vaginal wall, exactly opposite the ureterovesical junction, will now be seen a small dimple from the outer side of which an incision from one to one and a half inches long is made downward and outward along the course of the ureter. By careful blunt dissection the ureter is exposed and hooked down. If it is enlarged, as it commonly is in tuberculous cases, this is very easy. A metal hook or piece of suture material is passed around it and gentle traction facilitates its liberation through the broad ligament. If it is very large, one-half to three-quarters inch in diameter, it may be advisable either to ligate or to clamp and sever it, which renders it more mobile. If exsection from the bladder is thought desirable it may now be done, one layer of sutures being placed first and a second if deemed necessary after the exsection is made and the first layer of sutures tied. A ligature is then placed on the free end of the ureter if a clamp was used. The patient is next changed to the spuine position and opposite the lower pole of the affected kidney a transverse (Koenig) incision, four inches or longer, is made through the extraperitoneal portion of the abdominal wall. Its inner end need not be inside the semilunar line. The kidney is now freed and brought out through this incision, its vessels clamped or tied, and by gentle traction on the kidney the fingers are aided in separating the ureter from surrounding structures down to the pelvis, and it is easily pulled out of the wound. If careful dissection has not been accompanied by escape of pus from the kidney or ureter or from a perinephritic abscess, little attention to drainage will be needed. In two of his cases he has had to use both loin and vaginal drainage. In others, a piece of gauze was pushed by a uterine sound downward along the course of the ureter, through the vagina and vulva, only a strip being left in the abdominal portion of the cavity created by the operation. The loin wound was in these cases completely closed by buried animal sutures. The gauze was usually removed fractionally by daily pulling it down after the second day. If loin drainage is required it is frequently preferable to employ the stab-wound space for it, closing the Koenig incision completely.

To Relieve Itching.—Many different local medicaments may be employed to relieve severe itching, which is usually called pruritus. Pruritus ani is one of the most torturing of so-called minor ailments. In no other condition has the overworked phrase, "Remove the cause," such significance as in this trouble. If itching depends upon a lesion elsewhere or is of constitutional origin, the appropriate treatment suggests itself. Fresh pine tar is an effective remedy in relieving intolerable itching, although it is far from being esthetic. It is curative as well as soothing. Carbolic acid solutions relieve itching of the cuticle when used strongly and thus produce disagreeable after-effects. It is best to employcarbolic acid with glycerin or some oleaginous preparation. To relieve the itching produced by the bites of mosquitoes, "chiggers," etc., the spots may be touched with pure carbolic acid and immediately neutralized by an application of alcohol. Oil of peppermint or a strong menthol solution may also be of much value. Spirits of chloroform reinforced with chloral hydrate may be applied to itching parts on any portion of the body. This mixture should not be applied lavishly to the face, especially of thin-skinned people, lest it go more deeply than you desire. Menthol in alcohol or chloroform is effective in many types of itching. In the intolerable itching of anal pruritus it may be necessary to touch the affected parts with a 20 per cent soltion of silver nitrate in order to sear over the nerve terminals. It is seldom necessary in these distressing conditions to resort to the electric or actual cautery. It is better to begin with benign remedies and increase their potency until relief follows. In the majority of cases of itching of whatsoever kind the patient is manufacturing and excreting poisons upon which the trouble depends.—Medical Summary.

FAVORITE PRESCRIPTIONS

Applicatiou for Chilblains.—According to Jadassohn (Journal de medecine de Paris, October 30, 1909) the hands or feet affected should be bathed in hot water several times during the day. At night on retiring the following ointment should be applied:

℞ Ichthyol.....gr. xv to 3i
Resorcin.....gr. xv to gr. xlv
Wool fat.....3ii
Olive oil.....3iiss
Distilled water.....3iss
M. sec. art.

Nasal Catarrh.—The following combination has been found valuable to prevent incrustation of the nose in catarrhal conditions:

℞ Mentholi ..... gr. v
Camphorae..... gr. xx
Ol. eucalypti..... *m* xv
Petrolati..... 3j
M. Ft. ungt. Sig.: Apply locally to the nasal passages by means of cotton on an applicator.

Liquid petrolatum may be employed instead of the petrolatum, and used as a spray with an oil atomizer. Med. Bulletin.

Herpes.—

℞ Tinct. benzoini comp..... fl.3ij
Balsami peruviani..... fl.3j
Ungt. aq. rosae.....q, s. ad- 3j
M. Sig.:Apply several times a day.

Indications.—Used for herpes labialis, cold sores, or fever blisters, also in herpes zoster.

℞ Spir. camphorae.....fl.3iv

Sig.: Apply around lips with fingers frequently for several days before expected menstrual period.

Indications.—For prevention of anticipated menstrual herpes—Ex

Cough in Bronchitis.—

Ammonii chloridi 3iss
Tinct. hyoscyami..... fl.3iij
Syr. ipecacuanhae fl.3iss
Spir. frumenti..... fl.3j
Aquae chloroformi .....ad f3iv
M. Sig.: A teaspoonful in water every two hours.

Or:

Codeinae sulphatis..... grn. iv
Ammonii chloridi..... 3iss
Syr. ipecacuanhae..... fl. 3iss
Syr. acidi citrici,..... fl.3j
Aquae.....ad. fl.3iv
M. Sig.:One teaspoonful in water every two or three hours.—JourA.M.A..

MEDICAL MISCELLANY

Danger of Rest in the Treatment of Sprains.—Sprained ankles and knees are commonest on the football field, and I fancy that it has been largely from the experience gained in treating these football injuries that surgeons have come to realize the danger of rest. * * Gradually it has become evident that most of the disability after sprains resulted not from the sprain but from the treatment, the unhealthy stagnation of fluid about an unused joint, the resulting adhesions and muscular atrophy. Now our football surgeons treat their sprains by massage and moderate exercise from the outset, thus avoiding the stiffening, the atrophy and the tedious weeks of convalescence which they used to inflict.—Dr. Richard C. Cabot.

Business Training for Physicians.—The Wabash Business School for Physicians seems to be something unique and out of the ordinary, filling, we hope, a very important hiatus in the training of the medical man. The growing need for just such an institution as this is becoming more apparent each succeeding year. While it is true that the medical profession of today is a prime factor in securing the betterment of mankind, still the doctor is made to feel the sting of the fact that there is no class so poorly paid as his own. A course comprising the best methods of conducting the business end of practice will do much to help the physician to appreciate the hundred and one little facts which go to make a financially successful man. We believe that this will make the course given by this school a thing to be much sought after. We would advise our readers to send for a copy of "The Business Physician." Address Dr. D. S. Murphy, Wabash, Ind.

Changes in the Medical Department of the United States Navy Recommended by Surgeon General Rixey.—The annual report of Surgeon General Rixey, of the United States Navy, recommends the reorganization of the hospital corps, the establishment of a corps of dental surgeons and a medical reserve corps, the construction of two hospital ships, and a modification of the laws relative to fleet surgeons. Surgeon General Rixey also advocates a closer supervision of the physical exercise of the midshipmen at Annapolis by medical officers. He opposes the proposed requirement that officers shall do so many hours' watch on the deck of ships as an endurance test. He urges that it is not in keeping with the physical tests laid down by Ex-President Roosevelt.

SOCIETY PROCEEDINGS.

MEDICAL SOCIETY OF THE MISSOURI VALLEY.

Semi-Annual Meeting at Omaha, March 17 and 18

Physicians of the Missouri Valley are anticipating with pleasure the twenty-second semi-annual meeting of this society, to be held at Omaha, Thursday and Friday, March 17 and 18, under the presidency of Dr. A. B, Somers. Invitations have been sent to a number of men of national reputation, as well as to the presidents of all the State societies, within the province of this association. A number of applications have been received by the secretary for places on the program, and the interest in this meeting is already widespread.

The Oration on Surgery will be delivered by Dr. Leonard Freeman, of Denver, president of the Colorado State Medical Society. His subject, "Local Anesthesia," is a particularly timely one.

The Oration on Medicine will be delivered by Dr. Frank Parsons Norbury, Superintendent of the Illinois State Hospital for the Insane, at Kankakee, Illinois, the subject to be announced later.

The arrangements are under the auspices of the Omaha-Douglas County Medical Society, and a committee has been appointed, with Dr. John E. Summers as chairman, which alone insures a cordial welcome.

Members of the association desiring to present papers at this meeting will kindly send their titles to the secretary at once. Abstracts of papers must be furnished by February 20th, to insure a place on the program.

If you are not a member of this progressive society, send in your application at once to the secretary. Meetings in September and March of each year. Annual dues two dollars.

A cordial invitation is extended to the medical profession.

CHAS. WOOD FASSETT, Secretary,
St. Joseph, Mo.

Gelsemium will give good results where the lids are heavy, with inability to move them; dimness of sight with vertigo; dull feeling in eyes, with aching.

Sulphide of calcium is the remedy where the eyes are painful in a bright light; where there are pimples on the face and styes on the eyelids. It is also of value in ulceration of the cornea.

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meets in St. Louis, June 7 to 10.
"Come with us and we will do thee good."

THE MEDICAL FORTNIGHTLY
A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scentific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

Advertising forms close on the first and fifteenth of each month. Time should be allowed to submit proof for correction. Advertising rates on application.

Remittances and business communications should be addressed to the Fortnightly Press Co.

Subscription, $2.00 a year, in advance, including postage to any part of the United States, Mexico and Canada. Postage to foreign countries in the Universal Postal Union, including Newfoundland, $1.00 a year additional. Entered at the St. Joseph postoffice as second-class matter.

Subscriptions may begin at any time; volumes end with June and December.

Contributors should understand that corrected typewritten copy is essential to clean proof and prompt publication, and is much more satisfactory than manuscript. Original articles should be as condensed as justice to the subject will allow.

Editorial offices in St. Louis and St. Joseph, where specimen copies may be obtained, and subscriptions will be received.

Contributions and books for review should be addressed to the Managing Editor, 319 and 320 Century Building, St. Louis, Mo.

THE diner dropped his knife and fork with a clatter.

"Waiter!" he cried.

"Yes, sir," said the waiter.

"What's this stuff?" demanded the diner.

"Steak, sir, I think, replied the waiter, examining it closely. "Yes, there's no doubt it's steak, sir."

"But the smell!" roared the diner. "It must be weeks—Here smell for yourself."

The waiter shook his head, and bent confidentially over the diner's shoulder.

"You are making a little mistake, sir," he glancing cautiously round. "It's that other gentleman's fish you can smell."

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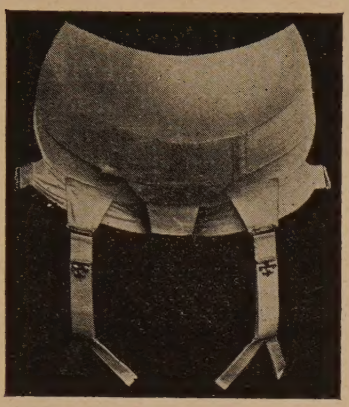

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MEDICAL MEMORANDA.

Risiccol (Castor Oil Powder, Siccolum Ricini.)—There is always room for new aperient—or, rather, in this particular case, for a new form of aperien Our old friend castor oil has various disadvantages, chief of which is the unpleasant taste and smell, not to mention the ease with which it can be adulterated. A good substitute is offered in the shape of a castor oil powder. It is a white, palatable powder, and in our hands has proved a safe, trustworthy, and mild, but efficient purgative, Like castor oil, it is specially suitable for children and delicate adults.—Medical Press, London.

The "Storm" Binder and Abdominal Supporter.—The profession is a unit in believing in the usefulness and actual necessity of some form of abdominal binder after operations upon that region. The variety of binders that have been put upon the market is almost without number. The very fact that so many different kinds have been in use indicates that most of them have been unsatisfactory. Dr. Katherine L. Storm, of Philadelphia, has placed upon the market a form of abdominal binder and supporter which bids fair to become the most popular of any yet introduced to the profession. This binder took the prize offered by the managers of the Woman's Hospital, of Philadelphia. It is a light, flexible, washable and durable appliance, without rubber or steel in its construction. It is used for any purpose for which an abdominal supporter may be needed for a man, woman or child. It Is applicable for general support, and, by means of a reinforcing strap, with pad, it may be used for local support as well, for instance, for hernia. It is especially valuable for movable kidney, enteroptosis or Glenard's disease. It is an ideal post-operative binder. It is a great comfort to women during the pregnant states. It is readily adjusted and produces no discomfort when worn. Measurements may be taken, and supporters ordered from the manufacturer, Katherine L. Storms, M. D., 1612 Diamond Street, Philadelphia, Pa. Those who have used the "Storm" binder have been particularly well pleased with it, and for this reason we are anxious that out readers should become acquainted with its many virtues. The company keeps a record of all measurements sent in, so that orders may be duplicated without difficulty or loss of time. All mail orders filled within twenty-four hours on receipt of price.—Wisconsin Med. Jour.

Glyco-Thymoline in Gynecological Conditions, with Particular Reference to Uterovaginal Catarrh.—(F. L. Newton, M. D., Boston, Mass.)—A novel way of using glyco-thymoline for vaginal leucorrhea will be of interest. Obtain a few sea sponges of fine soft quality. Cleanse and boil. Draw a thread or cord through one end of same, saturate it with glyco-thymoline (full strength) previously placed in a small dish or cup, say half an ounce. The application of the tampon is best made by the use of a Ferguson's speculum so placed as to expose or encircle the cervix uteri. With sponge filled with glyco-thymoline gently press through the speculum against the cervix and gradually withdraw speculum, patient being in lithotomy position with hips raised. If you wish, instruct the patient as to the method. Have her procure the sponges, also a glass piston formed vaginal syringe, half ounce or ounce capacity. Fill the syringe with the glyco-thymoline solution, insert into vagina, slowly pressing piston until syringe is emptied. Then insert a sponge tampon, previously saturated with glyco-thymoline (excess solution squeezed out). This is far superior to the cotton or wool tampon and can be outdrawn after twenty-four hours, washed and boiled and used again if desired. The treatment of mucous surfaces is interesting because effectual. Intra-uterine treatment, however, is a very delicate piece of work and should never be undertaken except by an experienced physician and under favorable conditions. A few of these conditions must be induced by the operator. First.—Dilatation of the os. Often the case is a multipara with a profuse uterine leucorrhea and careful use should be made of the dilator. Second.—Perfect asepsis—instruments sterilized and parts cleansed. Third.—Application of the medicament (glyco-thymoline) by saturating gauze or proper material for the purpose and if necessary introduce a uterine tubular speculum and blunt pointed and forked applicator. It is not necessary that prongs should be long or sharp but rather short and blunt and carefully passed through, carrying a narrow tape of gauze, single, carried to the fundus, then tufted in until cavity is lightly filled. Then with a syringe with fairly long beak pass through the speculum which is partially withdrawn or fully withdrawn, the glyco-thymoline can be forced into the packing until thorough saturation is procured, Is should be removed in twenty-four to forty-eight hours and may be repeated once to four times a week as indicated. The sponge tampon is inserted when the uterine packing is removed. There is no question of the efficacy of such treatment and its superiority to intra-uterine injections of iodine, pyrogallic acid, carbolic acid and cauterization by silver nitrate, etc.